

# CALIFORNIA'S HEALTH

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## The Developing Rheumatic Fever Program

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Rheumatic fever services became a part of the state crippled children's program on October 1st, when a \$500,000 legislative appropriation was made available to augment the crippled children's budget for this purpose. Prior to this year rheumatic fever services have been available only in a limited area of the State as a part of a special project financed from federal funds.

In apportioning the new state funds for rheumatic fever programs, the department has followed the pattern established in the crippled children services. Funds will be made available only to counties conducting crippled children's programs which meet the minimum standards for the care of physically handicapped children (Administrative Code, Title 17, Chapter 3, Group 1). Funds are immediately available to these counties. For counties which do not now meet the minimum standards, it is provided that funds may be apportioned if the county meets such standards by January 1, 1950.

### Standards of Care

These same standards for the care of physically handicapped children will apply to the rheumatic fever program. Diagnostic services, either in clinics or on an individual basis, will be provided by qualified personnel. Acute care will be provided in hospitals approved for crippled children services.

There is an additional factor to be considered in the treatment of children with rheumatic fever, however, and that is the relatively greater emphasis on the use of long-term facilities. Therefore, in addition to the institutions now approved under the minimum standards, certain other long-term facilities are being selected by the State Department of Public Health with consultation from the Heart Advisory Committee. Members

of this committee are now visiting such institutions and are making recommendations as to their use in the rheumatic fever program. It has been recommended that such facilities be affiliated with hospitals licensed by the State or eligible for such licensure as a "large general hospital."

The relationship of the long-term facility to the general hospital should be such that the appropriate services of the general hospital are readily available. Medical supervision of care provided in the long-term facility should be a responsibility of the staff of the general hospital. In addition to medical services, the facility should provide pediatric nursing services, educational services, medical social services, and occupational therapy.

It is not necessary that such personnel and facilities be available within the county as a requirement for the allotment of state rheumatic fever funds. Counties which now refer crippled children for care through the State Department of Public Health may make similar referrals in the case of children for whom rheumatic fever services are requested. The standard face sheet referral form may be used for this purpose. Diagnostic services will be arranged for these children in established clinics or in the offices of private physicians. Where institutional care is recommended, the family will be referred to the county for economic eligibility determination, and acute and long-term care will be planned for such children in the nearest approved institution.

In the near future it is hoped that itinerant field diagnostic clinics may be organized. These would be similar to those now being held in the orthopedic and



otological programs, and would serve either the individual county or, where feasible, groups of counties. From these clinics children in need of institutional care would be referred to the nearest approved institution.

Counties which conduct approved crippled children programs on an independent basis may wish to organize diagnostic and treatment programs using local personnel and facilities, or they may arrange to purchase such services elsewhere. In some instances it may be possible to plan only diagnostic services within the county, referring children in need of institutional care to facilities outside the county. The services of this department's staff, including consultation from members of the Heart Advisory Committee, are available for assistance in planning such local rheumatic fever programs.

#### Distribution of Funds

In apportioning funds for rheumatic fever services the department has made a real effort to make an equitable distribution within the limit of the total appropriation. Because of the difficulty of predicting individual county needs for diagnostic services, a portion of the appropriation has been reserved as a state fund for this purpose and is not included in the formula apportionment to each county. This is the same policy now followed in the state crippled children's program with respect to diagnostic services.

Since the rheumatic fever funds became available on October 1st of the current fiscal year they have been apportioned for treatment services over a nine-month period by the following formula:

1. State funds will be available in an amount equal to one-third of the county one-tenth mill appropriation for crippled children services. This money is immediately available to the counties for treatment provided after October 1st.
2. When the funds in Item 1 have been expended an additional \$10,000 will be made available.
3. Any special county appropriation for rheumatic fever (over the one-tenth mill appropriation made by the county) will be matched dollar for dollar to a maximum of \$20,000 of additional state money per county.

In order to remain within the budgetary appropriation of \$500,000 and to make maximum use of these funds, formula apportionments will be reviewed on February 15, 1950. On the basis of this review, state funds for *matching* (Item 3 in the formula) will be withdrawn where no local appropriations have been made for the rheumatic fever program, and other adjustments as indicated will be made.

As indicated previously, funds apportioned for rheumatic fever will be allotted only to counties conducting crippled children's programs which meet minimum standards. Counties which have not met this re-

quirement by January 1, 1950, will not be eligible to receive any allotments this fiscal year.

State funds for rheumatic fever care constitute an additional subvention to the counties, and are not to be confused with the subvention for basic crippled children services.

Eligibility for treatment in the rheumatic fever program will follow the pattern outlined in the Health and Safety Code (Section 255) for the basic crippled children program. All reimbursements received from families who are able to pay part of the cost for rheumatic fever treatment services will be reported quarterly to the State Department of Public Health, and the state apportionment will be reduced by this amount.

#### Historical Development

The action of the Legislature in making an appropriation for the care of children with rheumatic fever was the culmination of years of combined effort on the part of the medical profession, voluntary agencies and public health personnel. Consideration of the disease as a public health problem has been based not only on mortality and morbidity but on the need for broad organization of community resources to provide the long-term and costly care required.

About 20 years ago in California, rheumatic fever became the object of studies and investigations undertaken separately by various groups, both public and private.

These lines of effort gradually converged toward a clearly defined program, as general knowledge was gained of methods and costs of control. From 1940 on, federal funds supported demonstrations and special projects covering five counties in California, while case-finding and diagnostic centers were privately financed in six additional counties. With such experience, supplemented by the broad educational and community organization program undertaken by the Heart Division of the California Tuberculosis and Health Association, the need for an active program to control rheumatic fever was brought to the attention of the Legislature.

At the 1947 legislative session the State Department of Public Health was directed by a Senate concurrent resolution to "investigate the problem of rheumatic fever and rheumatic heart disease as it affects the children in this State who are in need of diagnostic treatment and hospital and convalescent care, including occupational therapy, medical social services and school health programs related to this disease and the costs of such care, the facilities needed to provide for them; to include the study of the problem in child health in the 1947 program, and to submit to the Legislature by January 1, 1949, a report on which it will be possible

to base a state-wide program for the care of rheumatic children."

Following this directive the department reviewed the experience of existing programs. It consulted with members of the medical profession, with voluntary agencies and with the Heart Advisory Committee in an effort to evaluate the real need and the methods of meeting it. In its report to the 1949 Legislature, the department recounted findings of an intensive study conducted in Contra Costa and Solano Counties from 1940 to 1946. This study involved the diagnosis, consultation and treatment of 1,097 rheumatic fever suspects referred by physicians, schools, health and welfare departments. Among these suspects, 666 had rheumatic fever and 303 required hospital and convalescent care. The cost of this care was greater than could be financed completely by most of the families. It is worthwhile to point out that 81 percent of these children were either born in California or had their first attack in this State.

The department reported also that, during 1947, in five counties having a school population of 108,000, there were 884 children suspected of having rheumatic fever who were referred for diagnosis. Of these, 572 were found to have rheumatic fever.<sup>1</sup> The inference was drawn that if the experience in these counties was applied to the whole California school population of 1,500,000 an estimated 12,300 children per year would be rheumatic fever suspects, 7,950 rheumatic fever cases, and of these 22 percent or 1,649 would require bed care outside the home.<sup>2</sup>

On the basis of this reported need the legislative appropriation was made. In the same report, the department outlined "an adequate rheumatic fever program in California." While it is recognized that such a program may not be realized everywhere in the State or in detail, it seems worthwhile to restate, as follows, the essential features of this reported program now that funds have become available for its primary development.

#### An Adequate Program in California

An adequate rheumatic fever program consists of developing methods of education of professional and lay groups; searching for the cases; verifying the diagnosis of rheumatic fever, seeing that the child is cared for during the activity of the illness, and maintaining medical and other supervision of the case through the inactive stage.

##### I. Education

An effective rheumatic fever control program presupposes both professional and lay groups oriented to the problems of rheumatic fever. This can be achieved by:

##### A. Education of Physicians.

1. Planning for such education through the medical schools; the California Medical Association and the

Heart Division of the California Tuberculosis and Health Association; post-graduate instruction programs, and the programs of the public health department and voluntary agencies.

2. Providing physicians with training through these sources so that they may assume leadership in the control of rheumatic fever.
3. Providing additional experience in diagnosis and treatment for medical practitioners in rural and urban areas through consultation services, teaching clinics and other post-graduate activities.

##### B. Community Education.

1. Study of the subject by community leaders, service clubs, parent-teacher organizations and other groups.

##### C. Training of Public Health and School Health Personnel.

1. Developing conferences, consultation methods and other education tools so that public health and school health personnel may become familiar with the problems of rheumatic fever and methods of control.

#### II. Case Finding

Through the educational methods outlined, a program of organized case finding will develop and will include:

- A. Recognition of suspected cases by medical, public health, and school health personnel.
- B. Referral of such cases to diagnostic services. Those requiring care should be directed either to private physicians or, where the family is shown unable to afford private care, to such public community resources as are available.

#### III. Making the Diagnosis

The diagnosis of rheumatic fever is difficult and time-consuming. It requires specially trained personnel, adequate facilities for examination, and pertinent laboratory tests, often repeated.

##### A. The diagnostic process involves:

1. Personal and family history taken by the physician.
2. Complete physical examination by the physician with special attention to signs of heart disease and other manifestations of rheumatic fever.
3. Laboratory tests consisting of X-rays and fluoroscopy, electrocardiography, blood count, and blood sedimentation rate, urine analysis, and such other tests as may be necessary in selected cases.

##### B. These facilities and staff are needed to carry out the above procedures and to interpret findings and make recommendations to the patient:

1. Physician, especially trained for work in this field.
2. Public Health Nurses, to assist both patient and physician.
3. Laboratory Technician, trained to do clinical laboratory procedures and X-rays.
4. Medical Social Service personnel, either attached to the facility or to a cooperating organization who can assist in planning with child and family.
5. Clerical personnel.
6. A suitable location, preferably an existing one, which will meet community needs.

#### IV. Care of the Child During the Active Stage of Illness

The primary object of this care is to minimize damage to the heart and thus reduce the number of permanent cardiac cripples. The necessary factors in good care are:

##### A. Continuous medical supervision, either by physicians with special training or by general practitioners with consultant service from the specialists' group. Such supervision should be by private physicians; or, where the family is shown to be unable to provide private care, it should be by such public community resources as are available.

##### B. Uninterrupted bed rest for the duration of the attack whether for weeks, months, or years, either at home or in an institution, which can be accomplished in the following ways:

1. Bed rest at home. About 50 percent of the cases are mild enough for this procedure.\*
2. Bed rest in an acute pediatric ward. This is required for the most acute cases and for those with severely damaged hearts.

<sup>1</sup>Trager, Brahna. *Study of a Two-County Demonstration Rheumatic Fever, 1940-1946*. Unpublished thesis.

<sup>2</sup>State Dept. of Public Health. *Investigation of Rheumatic Fever in California*. Report to the State Legislature, 1949.

\* Statement by T. Duckett Jones, authority on rheumatic fever, before a meeting of the San Francisco County Medical Society on October 23, 1947.



3. Bed rest and gradual resumption of activity in a foster home or convalescent institution for less severe and convalescent cases.
- C. Continued schooling by home teachers and in hospital schools.
- D. Suitable recreation and vocational guidance, and assistance in rehabilitation.
- V. Follow-up During the Inactive Stage of Illness:
  - A. Medical supervision at regular intervals, either by private physicians with consultant services available, or in follow up clinics, to discover early signs of recurrence of the disease, to evaluate heart damage and to relate the child's home and school life to the findings.
  - B. Public Health Nursing and School Health supervision to assist with problems of physical and social adjustment to school and home conditions.
  - C. Vocational rehabilitation for those cardiac cripples who need vocational training and placement.<sup>3</sup>

### Two Administrative Positions Open in San Diego

The San Diego Department of Civil Service and Personnel announces examinations for *Assistant Director of Public Health* and *Mental Health Consultant*, with date and time of interviews to be announced later.

County and state residence have been waived for both examinations. Applicants must be U. S. citizens and must not have passed their fifty-fifth birthday at the time of appointment.

Information about required qualifications and the nature of examinations is obtainable from the department of civil service and personnel at Room 402, Civic Center, San Diego 1, California. Requests should mention the examination numbers, which are: Assistant Director of Public Health, No. 1865; and Mental Health Consultant, No. 1864.

### Dr. Gilbert Writes on Photography in Public Health Work

If the public health worker is a good amateur photographer he will find many uses for his hobby on his job.

Dr. Roy O. Gilbert, Los Angeles County Health Officer, discusses some of the uses in an article, "Photography on Your Own Job," in the October issue of *American Photography*.

Photographs made by staff members of the Los Angeles County Health Department are used in professional and lay educational programs on slides, exhibits and posters and to illustrate pamphlets and newspaper publicity. They are also used for evidence in court cases. Occasionally photomicrography is used in the laboratory and clinics.

Dr. Gilbert's article is illustrated with excellent photographs taken by Ed Reinig, health educator with the County Health Department.

<sup>3</sup> State Dept. of Public Health. *Relating to the Investigation of Rheumatic Fever, 1949*. Report of the Department.

### Local Health Officers Conference Appoints Committees

Appointment of committees of the Conference of Local Health Officers for the coming year has been made by Dr. W. E. Turner, Health Officer of Santa Clara County and new president of the conference.

Dr. James C. Malcolm, Alameda County Health Officer, is Chairman of the Committee on Administrative Practices which consists of 13 local health officers. Following are the chairmen of study committees of this group:

*Environmental Sanitation*, Edward L. Russell, M.D., Orange County; *Health Center Construction*, Harold D. Chope, M.D., San Mateo County; *Maternal and Child Health*, Ira O. Church, M.D., Santa Barbara County; *Disease Control and Laboratories*, John R. Philp, M.D., Butte County; *Recruitment, Training and Personnel Standards*, Dwight M. Bissell, M.D., San Jose; *Records and Reports*, David Frost, M.D., Alameda County.

The following health officers were appointed to a joint committee with the California Medical Association: W. E. Turner, M.D.; J. B. Askew, M.D., San Diego City and County; Elmer M. Bingham, M.D., San Joaquin Local Health District; Harold D. Chope, M.D.; Robert S. Westphal, M.D., Riverside County; George M. Uhl, M.D., Los Angeles City; S. F. Farnsworth, M.D., Oakland.

### Sacramento Accepts V. N. A.

Local responsibility will be assumed in Sacramento for the Visiting Nurse Association on January 1st, when the agency becomes a participating member of the Community Chest. Previously, the V. N. A. was sponsored by the American Red Cross which started the agency as a demonstration 12 years ago. During that time the staff has grown from one nurse to 10 plus a clerk and a nurse director. Annual nursing visits have expanded from 1,300 to 14,000.

### Doctor-Public Liaison Is Aim of Local Board

A medical health advisory board has been established in Riverside County under sponsorship of the county medical society. Purpose of the board is to establish and preserve understanding and good relationships between doctors and the public.

The board, appointed by the medical society, consists of six physicians, including Dr. Robert S. Westphal, County Health Officer, and five laymen, including a county supervisor, a member of the city council, and a member of the board of education.

# New Communicable Disease Regulations

At its December meeting the State Board of Public Health approved numerous amendments to California's communicable disease regulations, which are contained in Title 17 of the California Administrative Code. Suggested changes were submitted by the State Department of Public Health following long and detailed study by staff and consulting epidemiologists, and their final form was shaped and approved by the State Conference of Local Health Officers.

The approved general revision simplifies many disease control regulations and brings them into accord with recent advances in preventive medicine and public health. The amendments were presented to the Board by Dr. Arthur C. Hollister, chief of the Acute Communicable Disease Service, who said the philosophical goals of their preparation were that they: (1) Should be as few as possible; (2) should enable, not force the local health officer to do things; (3) should be written broadly, to give the health officer ample latitude for action in varied situations; and (4) should reemphasize the importance of clinical observation in various diseases.

A basic change in the code is to make "physically handicapped children" reportable under Subchapter 1, the title of which is then revised to read "Reportable Diseases and Conditions." This single list will now be complete for all reporting purposes.

Under Article 1, procedure was changed to permit the reporting to the State of total numbers, instead of individual cases of certain common diseases (chickenpox, measles, etc.) for which detailed individual epidemiological information at the State Department is either unnecessary or impractical. Broader provisions were made for reporting outbreaks of disease of varied or unknown etiology.

An outline of the more significant amendments approved by the State Board of Public Health follows, in the order in which their subjects appear in the California Administrative Code.

**Diarrhea of the Newborn:** Definition of reportable cases of this disease is broadened to include infants up to one month of age instead of three weeks, and to include, for suspicion and observation, any newborn child discharged to its home who has watery stools within four days. If two or more cases occur in a nursery, all infants in the nursery shall be quarantined. Other newborns subsequently must be cared for in a different nursery by separate staff. If cases of diarrhea occur generally in a hospital, no more maternity cases may be admitted for the duration of the outbreak.

**Diphtheria:** Emphasis is shifted from laboratory search for carriers to search for missed cases and in-

creased clinical observation of close contacts. Age 15 is used as the dividing line for quarantine of household contacts. All contacts must be kept under daily medical supervision for clinical evidence of infection for seven days after the last exposure.

**Dysentery, Bacillary:** Isolation is changed to "modified," and carrier restrictions are reduced. Registry is dropped entirely.

**Food Poisoning:** Is defined as a group disease for reporting purposes. Botulism and salmonellosis are excluded from the group and handled separately. In the case of Salmonella infections, use of specific drugs are taken into account in the requirements for release from carrier and isolation restrictions. This is true also of typhoid fever, which is treated separately.

**Leprosy:** California is one of five endemic states in the U. S., but modern medical knowledge recognizes that the communicability of this disease is low and that historical stigmas attached to it are largely unwarranted. Thus regulations have been reasonably modernized in the new amendments. Isolation will now be applied only after diagnosis has been established certainly, and the degree of isolation will be determined by the local health officer. He, in turn, is urged to use a qualified consultant furnished by the State.

**Measles and Mumps:** Quarantine of contacts has been discarded except for special measles situations at discretion of the health officer. Mumps isolation has been redefined to no less than 10 days.

**Pertussis:** Quarantine of contacts has been dropped, but the isolation concept has been changed to prevent exposure of young children to the patient.

**Polioomyelitis:** Isolation becomes modified rather than strict, and is reduced from the old period of 14 days to seven days. Quarantine of contacts is discarded except for special situations (to be determined by the local health officer).

**Control of Psittacine Birds:** Separated from the disease psittacosis. It is recognized that aviaries in California are no longer an important source of infection, and the state permit system has been dropped. Federal regulations will still apply to shipment of birds. Aviarists are required to maintain records of all transactions involving psittacine birds.

**Rabies:** Health officers are to be notified of bites and the existence of suspected rabid animals. Bitten persons are to be advised to seek treatment. Suspected animal confinement is increased from 10 to 14 days. Rabies-subject animals bitten by a known rabid animal or in intimate contact with them shall be isolated for observation for 120 days, or shall be destroyed. Health officers shall impose quarantine restrictions.

### New Water Pollution Control Law in Effect

California's system of water pollution control was changed December 15th when legislation setting up a State Water Pollution Control Board and nine regional boards went into effect.

The new law is contained in Division 7 of the State Water Code. In addition, the provisions of the Health and Safety Code relating to the permit system administered by the State Department of Public Health are repealed and replaced—to conform with the control board system written into the Water Code—with a new version of Articles 2 and 3 of Chapter 6, Part 3, Division 5.

Membership of the State Water Pollution Control Board consists, under the law, of the Director of Public Health, State Engineer, Director of Natural Resources, and Director of Agriculture ("or their nominees"); plus nine members appointed by the Governor and preferably chosen from each of the nine regions defined in Section 13040 of the Water Code.

This body in turn appoints a registered engineer experienced in the field of waste disposal and control of pollution to serve as its executive officer. Already chosen on a temporary basis, the acting Executive Officer is Frank M. Stead, Chief of the Bureau of Environmental Sanitation, State Department of Public Health, who will serve on loan from the department.

At this time, policies and plans of the State Water Pollution Control Board are being formulated, while regional boards are in process of organization. Provisions of the new law may be briefed as follows:

1. Distinction is made between contamination (actual health hazard), pollution (interference with beneficial uses of water) and nuisance (odors and unsightliness).
2. Control of pollution and nuisance is to be on a regional level, by a system of individual orders.
3. Control authority is vested primarily in regional five-man boards representing the major interests in pollution control.
4. Paramount state authority is vested in the 13-man state board, representing both the special interests and the geographical areas of the State.
5. Four state departments through their directors have membership in the state board.
6. Technical field studies for both the state and regional boards are carried on by the staffs of existing state and local agencies (except for the technical executive officers and staffs of the boards).
7. Authority to correct cases of contamination is vested with state and local health departments.
8. The state permit system is abolished.

9. State and local health departments have parallel powers and responsibilities to correct cases of contamination.

The law provides that members of both state and regional boards shall be representative of interests concerned with water pollution.

Names and representation of members of the State Water Pollution Control Board are:

Warren T. Hannum, State Director of Natural Resources, Chairman; Wilton L. Halverson, M.D., State Director of Public Health; A. A. Brock, State Director of Agriculture; Edward Hyatt, State Engineer;

Gerald E. Arnold, San Diego Water Department; Mrs. Lelia Baeskens, agricultural landowner, Orange County; Keith Mets, agricultural landowner, Imperial County; Ralph E. Sanborn, California Packing Corp., San Francisco; Don D. Lucas, Kern River Oil Field Co., Bakersfield; J. J. Krohn, California Barrel Co., Arcata; A. M. Rawn, Los Angeles County Sanitation District, Los Angeles; Don McMillan, City Manager, Pasadena; Wirt Morton, Santa Barbara County Planning Commission, Santa Barbara.

Forthcoming issues of *California's Health* will carry names of members of regional boards and information concerning program as it is developed.

### Sewage Chlorination Halted by L. A., Orange Counties

Quarantine limits on the beaches of Los Angeles and Orange Counties will remain in effect during the winter, but chlorination can be discontinued temporarily, under a resolution approved by the State Board of Public Health at its meeting of December 9th in Los Angeles.

The request to discontinue chlorination of sewage was made by the City of Los Angeles and by the Orange County Joint Outfall Sewer District, on the plea that few swimmers use the beaches during winter months. The board took cognizance of surveys of beach use made in recent weeks, but asked that further studies be reported at its meeting next February 14th. A date when chlorination must be resumed will be set at that time.

In a related discussion, the board heard testimony for and against a change in the bacteriological standards now used by California to determine when salt water is safe for swimming.

The Board of Public Health agreed with spokesmen of the State's Bureau of Sanitary Engineering that the present permissible count of 10 *E. coli* per 100 cc. is a reasonable standard which should be retained.



## State Hospital Council Approves More Construction

Eight projects were approved for hospital construction funds by the State Advisory Hospital Council at its December meeting, bringing to 41 the projects sanctioned since inception of the state-federal subsidy program.

At the same session the council discussed new amendments to the Hill-Burton Act which extend and double the federal appropriation for the national hospital program. California will now receive \$5,000,000 annually through the fiscal year ending June 30, 1955. Among "matching" alternatives offered by the new amendments, the council decided to continue its allocations of one-third federal matching funds to each applicant selected for award.

Only two of the eight applicants approved at the December meeting were tax-supported institutions eligible for state as well as federal allotments. These were the Stanislaus County Hospital and the Calexico Municipal Hospital. The eight projects, all general hospitals, are listed below:

*Mercy Hospital*, Redding, 75 bed hospital. Federal share, \$422,430.

*Poster Memorial Hospital*, Ventura, 23 bed maternity section. Federal share, \$141,617.

*St. John's Hospital*, Oxnard, 75 bed hospital. Federal share, \$422,430.

*San Jose General Hospital*, San Jose, 70 bed addition. Federal share, \$316,500.

*O'Connor Hospital*, San Jose, 100 bed hospital. Federal share, \$42,677.

*Lodi Memorial Hospital*, Lodi, 57 bed hospital. Federal share, \$329,217.

*Stanislaus Co. Hospital*, Modesto, central facilities unit. Federal-state shares each, \$323,772.

*Calexico Municipal Hospital*, Calexico, 20 bed hospital. Federal-state shares each, \$70,000.

## Graduate Nurse Examination

Applicants accepted for the March 16th-17th examination of the State Board of Nurse Examiners, but who have not yet received their license as registered nurse, may have that test count as a State Personnel Board examination. It is necessary to be a U. S. citizen and to file an application with the Personnel Board by March 31, 1950.

No second written examination will be required. Newly licensed nurses will be placed on the civil service eligible list in accordance with their examination ratings.

## Butte County Bulletin

*Your Health Department Reports*, published by the Butte County Health Department, is the latest of the many periodical bulletins issued by California health departments to inform the community of local public health programs and problems. The first issue is dated November 15th and is mimeographed. Although not stated, presumably *Reports* will be issued monthly.

## Extent of Rabies Problem Revealed by Study Report

For the first time, California has learned the real extent of its rabies problem and what is or is not being done about it in the State. On the basis of this information a control program will be developed.

An extensive survey of the problem was made by the Rabies Study Committee appointed last April by the State Director of Public Health. The findings were reported to the Conference of Local Health Officers at its November meeting. Recommendations for control will be developed by the Committee in cooperation with the Conference.

Members of the Rabies Study Committee include George Hart, M.D., D.V.M., Dean of the U. C. School of Veterinary Medicine; Robert Westphal, M.D., Health Officer of Riverside County; and, from the State Department of Public Health, Frank M. Steed, Robert Dyar, M.D., Ben H. Dean, D.V.M., George L. Humphrey, D.V.M., David D. Holaday, M.D., and A. C. Hollister, M.D. The job assigned to this group was the comprehensive one of studying the whole human and animal rabies problem of the State. Highlights of this study appear below.

### How Big a Problem Is Rabies in California?

In the 11 years between 1937 and 1948, 9,395 cases of animal rabies were reported in California, and 93 percent of these occurred in dogs.

In 1948, there were 36,122 reported animal bites in 31 counties, and an estimated 41,000 in the State as a whole.

In 1948, a total of 3,334 Pasteur treatments were sold in California by seven biological companies, which estimate that at least 95 percent of the treatments were actually administered.

The total estimated cost of these treatments approximated \$316,700.

### Status of Dog and Rabies Control Measures

A survey was done on 31 counties which contain 86 percent of the State's population and 54 percent of its land area.

In this survey area, during 1948, an estimated bill of \$1,161,428 was paid for the investigation of animal bites, quarantine activities, stray animal impoundment and destruction, laboratory costs, and the administrative time of local health departments involved in dog activities.

On the other hand, these counties in the survey area took in an estimated revenue of \$913,863 from dog licensing fees, fines, and sales, even though fewer than half of the dogs were licensed.

The amount of revenue which can be garnered by an actively administered, effective rabies control pro-

gram appears capable, from the facts gathered by the Rabies Study Committee, of financing the costs of the program. But at the present time such a program is far from being realized in California. Only 27 counties have any rabies ordinances. Only 23 of these license their dogs; only 24 have pound facilities; only 15 of these counties quarantine biting dogs, and only seven require vaccination. A chart of the State's local rabies control programs, the study committee points out, "shows the great lack of uniformity between the existing county ordinances"; (and moreover) "this chart includes all of the county dog control ordinances now in effect in California without regard to whether or not the ordinances are being enforced."

#### Conclusions

The Rabies Study Committee, after consideration of all the assembled data, concluded that:

a. Animal rabies is endemic in California and is a major public health problem.

b. Reduction in the necessity for and the total number of Pasteur treatments being given in the State, constitutes the major responsibility of public health officials in respect to rabies.

Elements which need to be included in a control system, the Committee points out, are: registration and licensing of all dogs, maintenance of a pound and quarantine system, annual anti-rabies vaccination of all dogs, and public education.

### Sanitary Inspector Retires After 29 Years' Service

On January 1, 1950, William O. Deal of this department's Bureau of Vector Control retires after 29 years of distinguished service to the State. Mr. Deal was appointed as Sanitary Inspector in 1921, after having served in the same capacity since 1908 with the U. S. Public Health Service. His varied activities have covered plague outbreaks in Los Angeles, San Francisco and Oakland; the beginnings of mosquito control; and emergency sanitation work in the St. Francis Dam disaster, the Long Beach and Santa Barbara earthquakes, and the Sacramento Valley floods.

Among the more recent of Mr. Deal's achievements are the development of public and interdepartment relationships in the control of disease vectors in the Tahoe region, and the organization of the East Bay Rat Control Committee.

Bill Deal's friendly and cooperative personality has contributed to the maintenance of close relationships between the department and many local agencies. His years of devoted service in his field have been widely effective, and are deeply appreciated.

## California Morbidity Report November, 1949

### Civilian Cases

Reportable diseases	Week ending					Total cases	5-yr. median	1944-1948 Nov.
	11-5	11-12	11-19	11-26	12-3			
Amebiasis (amebic dysentery).....	2	9	2	7	7	27		
Anthrax.....	1		1	2		4		
Botulism.....								
Chancroid.....	14	6	5	6	14	45		
Chickenpox (varicella).....	262	264	361	365	480	1,732	1,497	(42)
Cholera, Asiatic.....								
Coccidioid granuloma.....	5	1	1	2	1	10		
Conjunctivitis—acute infectious of the newborn (ophthalmia neonatorum).....				2		2		
Dengue.....								
Diarrhea of the newborn.....	12	8		6		26		
Diphtheria.....	14	8	17	11	6	56	99	
Dysentery, bacillary.....	10	23	13	7	9	68		
Encephalitis, infectious.....	3	1	3	25	32	153	4	
Epilepsy.....	35	28	33	194	1	202		
Food poisoning.....	1	1	5			7		
German measles (rubella).....	36	51	44	33	35	199		
Glanders.....								
Gonococcus infection.....	447	333	354	367	373	1,874	2,119	(41)
Granuloma inguinale.....					1	1		
Influenza, epidemic.....	7	4	8	6	13	38	42	
Jaundice, infectious.....	9	13	5	3	5	35		
Leprosy.....		2		1		3		
Lymphogranuloma venereum (lymphopatia venereum, lymphogranuloma inguinale).....	8	5	8	3	4	28		
Malaria.....				1		1	12	
Measles (rubeola).....	31	39	63	73	63	269	735	(41)
Meningitis, meningococci.....	5	1	3	4	10	23	30	
Mumps (parotitis).....	358	398	473	448	661	2,338	1,691	(47)
Paratyphoid fever, A, B and C.....	4	4	9	3	9	29		
Plague.....								
Pneumonia, infectious.....	21	20	26	30	32	129	129	(41)
Polymyelitis, acute anterior.....	80	84	80	49	39	332	111	(41)
Psittacosis.....	3		2			5		
Rabies, human.....								
Rabies, animal.....								
Relapsing fever.....				2		2		
Rheumatic fever.....	4	10	3	4	16	37		
Rocky Mountain spotted fever.....	76	82	101	93	116	468	549	(41)
Scarlet fever.....	12	9	14	11	8	54		
Streptococci sore throat.....								
Smallpox (variole).....	250	189	250	220	236	1,160	1,518	(41)
Syphilis.....	1		1			2		
Tetanus.....								
Trachoma.....								
Trichinosis.....	2					2		
Tuberculosis, pulmonary.....	156	133	134	141	143	707	549	(41)
Tuberculosis, other forms.....	6	9	4	6	8	33	48	
Tularemia.....	2					2		
Typhoid fever.....	2	1	1		3	7	13	
Typhus fever.....								
Undulant fever (brucellosis).....	6	1	1	1	7	16	11	
Whooping cough (pertussis).....	71	83	94	83	131	462	204	(41)
Yellow fever.....								
Spirochetal jaundice.....								
						10,595		200,138

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